FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028860

Facility Name: Lexington Health Care Center-Lombard

Address: 2100 S. Finley Road (Number) Lombard (City) 60148 (Zip Code)

County: DuPage

Telephone Number: (630) 495-4000 **Fax #** (630) 495-2809

IDPA ID Number: 363252724001

Date of Initial License for Current Owners: 10/09/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,686	9,323	5,926	24,935	8
9	SNF/PED					9
10	ICF	30,449	18,766	781	49,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,135	28,089	6,707	74,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.65%

D. How many bed-hold days during this year were paid by Public Aid? 44 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/9/84

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 31 and days of care provided 5,654

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	345,858	27,393	12,390	385,641		385,641		385,641			1
2	Food Purchase		279,126		279,126		279,126	(11,699)	267,427			2
3	Housekeeping	342,233	44,309		386,542		386,542		386,542			3
4	Laundry	31,056	28,541		59,597		59,597	(12,248)	47,349			4
5	Heat and Other Utilities			248,347	248,347		248,347	3,198	251,545			5
6	Maintenance	73,254		142,907	216,161		216,161	9,184	225,345			6
7	Other (specify):*											7
8	**TOTAL General Services**	792,401	379,369	403,644	1,575,414		1,575,414	(11,565)	1,563,849			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	3,008,958	195,825	7,464	3,212,247		3,212,247		3,212,247			10
10a	Therapy			619,672	619,672		619,672		619,672			10a
11	Activities	230,056	23,052	3,314	256,422		256,422		256,422			11
12	Social Services	25,607		2,944	28,551		28,551		28,551			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,264,621	218,877	650,394	4,133,892		4,133,892		4,133,892			16
	C. General Administration											
17	Administrative	189,040		397,135	586,175		586,175	(397,135)	189,040			17
18	Directors Fees											18
19	Professional Services			37,666	37,666		37,666	4,295	41,961			19
20	Dues, Fees, Subscriptions & Promotions			22,076	22,076		22,076	3,292	25,368			20
21	Clerical & General Office Expenses	422,244	34,468	22,105	478,817		478,817	21,955	500,772			21
22	Employee Benefits & Payroll Taxes			621,498	621,498		621,498	58,324	679,822			22
23	Inservice Training & Education			320	320		320		320			23
24	Travel and Seminar			2,808	2,808		2,808	1,672	4,480			24
25	Other Admin. Staff Transportation			19	19		19	9,672	9,691			25
26	Insurance-Prop.Liab.Malpractice			120,379	120,379		120,379	2,382	122,761			26
27	Other (specify):*											27
28	**TOTAL General Administration**	611,284	34,468	1,224,006	1,869,758		1,869,758	(295,543)	1,574,215			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,668,306	632,714	2,278,044	7,579,064		7,579,064	(307,108)	7,271,956			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington Health Care Center-Lombard #0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			55,870	55,870		55,870	134,820	190,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							221,369	221,369			32
33	Real Estate Taxes							130,726	130,726			33
34	Rent-Facility & Grounds			1,328,908	1,328,908		1,328,908	(1,328,908)				34
35	Rent-Equipment & Vehicles			2,560	2,560		2,560	658	3,218			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,387,338	1,387,338		1,387,338	(841,335)	546,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,225	28,800	148,025		148,025		148,025			39
40	Barber and Beauty Shops			39,090	39,090		39,090		39,090			40
41	Coffee and Gift Shops			685	685		685		685			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable costs			45,854	45,854		45,854	(45,854)				43
44	**TOTAL Special Cost Centers**		119,225	237,069	356,294		356,294	(45,854)	310,440			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,668,306	751,939	3,902,451	9,322,696		9,322,696	(1,194,297)	8,128,399			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(71)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(12,248)	4		8
9	Non-Straightline Depreciation	1,178	30		9
10	Interest and Other Investment Income	(20,055)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,760)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(545)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,640)	43		24
25	Fund Raising, Advertising and Promotional	(8,909)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(43,234)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	4,957			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,327)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,109,970)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,109,970)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,194,297)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860
1/1/01 - 12/31/01 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Non-allowable collections expense	(2,664)	19
Out of period legal fees	(497)	19
Amortized deferred maintenance	8,118	6
Total	4,957	

See Accountants' Compilation Report

STATE OF ILLINOIS

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(71)	0	0	0	0	0	0	0	0	0	0	(71)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,248)	0	0	0	0	0	0	0	0	0	0	(12,248)	4
5	Heat and Other Utilities	0	0	3,198	0	0	0	0	0	0	0	0	3,198	5
6	Maintenance	0	0	1,066	0	0	0	0	0	0	0	0	1,066	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,319)	0	4,264	0	0	0	0	0	0	0	0	(8,055)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(397,135)	0	0	0	0	0	0	0	(397,135)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50	7,406	0	0	0	0	0	0	0	0	7,456	19
20	Fees, Subscriptions & Promotions	0	0	3,292	0	0	0	0	0	0	0	0	3,292	20
21	Clerical & General Office Expenses	0	555	21,400	0	0	0	0	0	0	0	0	21,955	21
22	Employee Benefits & Payroll Taxes	0	0	46,696	0	0	0	0	0	0	0	0	46,696	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,672	0	0	0	0	0	0	0	0	1,672	24
25	Other Admin. Staff Transportation	0	0	9,672	0	0	0	0	0	0	0	0	9,672	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,382	0	0	0	0	0	0	0	2,382	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	605	90,138	(394,753)	0	0	0	0	0	0	0	(304,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,319)	605	94,402	(394,753)	0	0	0	0	0	0	0	(312,065)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,178	120,520	0	13,122	0	0	0	0	0	0	0	134,820	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,055)	240,136	0	1,288	0	0	0	0	0	0	0	221,369	32
33	Real Estate Taxes	0	128,908	0	1,818	0	0	0	0	0	0	0	130,726	33
34	Rent-Facility & Grounds	0	(1,328,908)	0	0	0	0	0	0	0	0	0	(1,328,908)	34
35	Rent-Equipment & Vehicles	0	0	0	658	0	0	0	0	0	0	0	658	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,877)	(839,344)	0	16,886	0	0	0	0	0	0	0	(841,335)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(58,088)	12,234	0	0	0	0	0	0	0	0	0	(45,854)	43
44	**TOTAL Special Cost Centers**	(58,088)	12,234	0	0	0	0	0	0	0	0	0	(45,854)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,284)	(826,505)	94,402	(377,867)	0	0	0	0	0	0	0	(1,199,254)	45

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health		
John Samatas	33.33%	See Attached Schedule B	See Attached	Care Systems of		
Cynthia Thiem	33.34%		Schedule B	Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,328,908	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	$	$ (1,328,908)	1
2	V	19	Professional fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	50	50	2
3	V	21	Bank charges		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	450	450	3
4	V	21	Office supplies		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	105	105	4
5	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	120,520	120,520	5
6	V	32	Interest expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	237,682	237,682	6
7	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	7
8	V	33	Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	128,908	128,908	8
9	V	43	State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	12,234	12,234	9
10	V								10
11	V								11
12	V				** - The owners of Lexington Health Care Center of Lombard, Inc. own				12
13	V				100% of Lexington Health Care Systems of Lombard Limited Partnership				13
14	Total			$ 1,328,908			$ 502,403	$ * (826,505)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660 **Schedule B**
1/1/01 - 12/31/01

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	Utilities - gas & electric	$	Royal Management Corp.	**	$ 2,829	$ 2,829	15
16	V		5	Utilities - water & sewer		Royal Management Corp.	**	369	369	16
17	V		6	Repairs & maintenance		Royal Management Corp.	**	742	742	17
18	V		6	Scavenger & exterminating		Royal Management Corp.	**	310	310	18
19	V		6	Security service		Royal Management Corp.	**	14	14	19
20	V		19	Computer consultant & supplies		Royal Management Corp.	**	5,663	5,663	20
21	V		19	Professional fees		Royal Management Corp.	**	1,743	1,743	21
22	V		20	Advertising - help wanted		Royal Management Corp.	**	2,694	2,694	22
23	V		20	Dues & subscriptions		Royal Management Corp.	**	598	598	23
24	V		21	Bank charges		Royal Management Corp.	**	3,226	3,226	24
25	V		21	Communications		Royal Management Corp.	**	583	583	25
26	V		21	Office supplies & printing		Royal Management Corp.	**	6,960	6,960	26
27	V		21	Postage		Royal Management Corp.	**	2,939	2,939	27
28	V		21	Telephone		Royal Management Corp.	**	7,692	7,692	28
29	V		22	FICA		Royal Management Corp.	**	28,646	28,646	29
30	V		22	FUTA		Royal Management Corp.	**	591	591	30
31	V		22	SUTA		Royal Management Corp.	**	1,119	1,119	31
32	V		22	Insurance - W/C		Royal Management Corp.	**	361	361	32
33	V		22	Insurance - Hospitalization		Royal Management Corp.	**	11,962	11,962	33
34	V		22	401(k) and other emp. benefits		Royal Management Corp.	**	4,017	4,017	34
35	V		24	Travel & seminar		Royal Management Corp.	**	1,672	1,672	35
36	V		25	Auto expense		Royal Management Corp.	**	9,672	9,672	36
37	V									37
38	V			** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total				$			$ 94,402	$ * 94,402	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - general	$	Royal Management Corp.	**	$ 2,382	$ 2,382	15
16	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,027	4,027	16
17	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,479	2,479	17
18	V	30	Depreciation - equipment		Royal Management Corp.	**	6,616	6,616	18
19	V	32	Interest		Royal Management Corp.	**	1,288	1,288	19
20	V	33	Property taxes		Royal Management Corp.	**	1,818	1,818	20
21	V	35	Equipment rental		Royal Management Corp.	**	658	658	21
22	V	17	Management	397,135	Royal Management Corp.	**		(397,135)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 397,135			$ 19,268	$ * (377,867)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	10%	Salary	$ 40,322	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33%	See Schedule C	2	4%	Salary	17,732	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	5%	Salary	22,250	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4%	Salary	9,084	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	12,260	L 17, C 1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 101,648		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860 **Schedule C**
1/1/01 - 12/31/01

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	145,293	330,395	182,313	74,433	100,457	832,891

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	$ 26,007	$	81,760	$ 2,829	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397		81,760	369	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818		81,760	742	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851		81,760	310	4
5	6	Security Service	Bed Days	751,703	11	125		81,760	14	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068		81,760	5,663	6
7	19	Professional fees	Bed Days	751,703	11	16,027		81,760	1,743	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766		81,760	2,694	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496		81,760	598	9
10	21	Bank charges	Bed Days	751,703	11	29,664		81,760	3,226	10
11	21	Communications	Bed Days	751,703	11	5,359		81,760	583	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988		81,760	6,960	12
13	21	Postage	Bed Days	751,703	11	27,021		81,760	2,939	13
14	21	Telephone	Bed Days	751,703	11	70,716		81,760	7,692	14
15	22	FICA	Bed Days	751,703	11	263,374		81,760	28,646	15
16	22	FUTA	Bed Days	751,703	11	5,433		81,760	591	16
17	22	SUTA	Bed Days	751,703	11	10,292		81,760	1,119	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319		81,760	361	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982		81,760	11,962	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931		81,760	4,017	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373		81,760	1,672	21
22	25	Auto expense	Bed Days	751,703	11	88,927		81,760	9,672	22
23										23
24										24
25	TOTALS					$ 867,934	$		$ 94,402	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance - general	Bed Days	751,703	11	$ 21,896	$	81,760	$ 2,382	1
2	30	Depreciation - vehicles	Bed Days	751,703	11	37,022		81,760	4,027	2
3	30	Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		81,760	2,479	3
4	30	Depreciation - equipment	Bed Days	751,703	11	60,826		81,760	6,616	4
5	32	Interest	Bed Days	751,703	11	11,844		81,760	1,288	5
6	33	Property taxes	Bed Days	751,703	11	16,719		81,760	1,818	6
7	35	Equipment rental	Bed Days	751,703	11	6,049		81,760	658	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 177,145	$		$ 19,268	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		x	Mortgage	$39,766.00	04/11/94	$ 3,978,766	$ 2,596,879	04/11/09	0.0875	$ 237,682	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$39,766.00		$ 3,978,766	$ 2,596,879			$ 237,682	9
	B. Non-Facility Related*											
10								Interest income offset			(20,055)	10
11								Amortization of mortgage costs			2,454	11
12								Allocation from management company			1,288	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,313)	14
15	TOTALS (line 9+line14)						$ 3,978,766	$ 2,596,879			$ 221,369	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.		$ 143,000	1
	Allocated from management company	1,818	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 133,908	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,274)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 138,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 130,726	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	126,636	8
1997	130,718	9
1998	134,318	10
1999	135,483	11
2000	133,908	12

2000 tax:	133,908
Estimated increase:	1.03
Estimated 2001 taxes:	137,925
Use:	138,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Lombard COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028860

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-19-307-002	Land and building	$ 133,907.50	$ 133,907.50
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 68,214.22	$ 1,818.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 202,121.72	$ 135,725.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lombard Lexington Square Life Care, Inc.: Retirement Community; 263 units; 309,000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1984	$ 616,761	1
2					2
3	TOTALS	30,000		$ 616,761	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1984	1984	$ 3,661,473	$	35	$ 104,614	$ 104,614	$ 1,802,404	4
5	9		1995	1995	284,156	8,119	35	8,119		52,771	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1990	96,217		10			96,217	9
10	Building Improvements			1991	71,493		10	2,979	2,979	70,896	10
11	Building Improvements			1994	20,200		10	2,020	2,020	15,150	11
12	Building Improvements			1995	14,535	415	35	415		2,700	12
13	Building Improvements - dishwater hood			1996	2,748	275	10	275		1,511	13
14	Building Improvements - outside painting			1996	11,308	1,131	10	1,131		6,219	14
15	Building Improvements - dining room			1996	3,752	375	10	375		2,064	15
16	Leasehold Improvements			1992	16,299	466	35	466		4,425	16
17	Leasehold Improvements			1994	21,836	2,184	10	2,184		16,377	17
18	Leasehold Improvements - 2nd floor			1996	19,319	1,932	10	1,932		10,625	18
19	Leasehold Improvements - bathroom rehab			1996	9,216	922	10	922		5,069	19
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		1,016	20
21	Land Improvements			1993	2,985	199	15	199		1,692	21
22	Land Improvements			1995	4,596	306	15	306		1,991	22
23	Capitalized Repairs			1986	1,730		10			1,730	23
24	Building Improvements - basement			1996	18,993	1,899	10	1,899		9,022	24
25	Leasehold Improvements - Corner Guards			1997	520	52	10	52		234	25
26	Leasehold Improvements - Corridor flooring			1997	10,381	1,038	10	1,038		4,671	26
27	BI: Kitchen Rehab			1998	2,494	249	10	249		873	27
28	Wiring for MDS project			1998	3,365	337	10	337		1,178	28
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		460	29
30	Tile for Lobby			1998	20,530	2,053	10	2,053		7,186	30
31	Walk in Freezers/Coolers			1998	3,182	91	35	91		318	31
32	Fire Wall Repairs			1998	12,410	355	35	355		1,241	32
33	Underground storage tank			1998	2,613		10	262	262	1,048	33
34	Repave parking lot			1999	7,625	508	15	508		1,271	34
35	Lounge Floor Tile			1999	2,964	296	10	296		741	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rewire Building	1999	$ 9,083	$ 260	35	$ 260	$	$ 649	37
38	Heat exchanger for water heater	1999	1,660		5	332	332	830	38
39	Compressor and tank for freezer	1999	2,924		5	584	584	1,461	39
40	Plumbing Improvements	2000	2,833	283	10	283		425	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		94	41
42	Water heater repairs	2000	3,831	766	5	766		1,149	42
43	Automatic door	2000	4,556	130	35	130		195	43
44	Install sprinklers	2001	6,082	355	10	355		355	44
45	Infrared curtains for elevator	2001	4,500	75	10	75		75	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,375,878	$ 25,456		$ 136,247	$ 110,791	$ 2,126,333	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,375,878	$ 25,456		$ 136,247	$ 110,791	$ 2,126,333	1
2	Allocated from management company	1995	10,923		35	338	338	2,029	2
3	Allocated from management company	1996	8,890		35	275	275	1,397	3
4	Allocated from management company	1989	306		31	9	9	134	4
5	Allocated from management company - HVAC	1998	230		35	7	7	26	5
6	Allocated from management company - Offices	1999	581		35	18	18	42	6
7	Allocated from management company - Offices	2000	276		35	9	9	14	7
8	Allocated from management company	1987	56,207		31	1,741	1,741	24,616	8
9	Allocated from management company	1993	30		39	1	1	6	9
10	Allocated from management company	1995	1,266		39	39	39	210	10
11	Allocated from management company	1996	254		39	8	8	34	11
12	Allocated from management company - Sidewalk	1998	529		39	16	16	46	12
13	Allocated from management company - Roof	1998	19		15	1	1	6	13
14	Allocated from management company - Awnings	1999	149		39	5	5	10	14
15	Allocated from management company - Parking lot	1999	327		15	10	10	75	15
16	Allocated from management company - Facade	2001	46		15	1	1	1	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,455,911	$ 25,456		$ 138,726	$ 113,270	$ 2,154,979	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,455,911	$ 25,456		$ 138,726	$ 113,270	$ 2,154,979	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,455,911	$ 25,456		$ 138,726	$ 113,270	$ 2,154,979	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,455,911	$ 25,456		$ 138,726	$ 113,270	$ 2,154,979	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,455,911	$ 25,456		$ 138,726	$ 113,270	$ 2,154,979	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 269,526	$ 10,907	$ 39,730	$ 28,823	5-10 years	$ 132,935	71
72	Current Year Purchases	21,871	1,591	1,591		5-10 years	1,591	72
73	Fully Depreciated Assets	1,124,214					1,124,214	73
74	Allocated from Management Company	71,466		6,616	6,616		51,927	74
75	TOTALS	$ 1,487,077	$ 12,498	$ 47,937	$ 35,439		$ 1,310,667	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Chevy Van	1987	$ 20,061	$	$	$	5	$ 20,061	76
77										77
78										78
79	Allocated from Management Company			32,352		4,027	4,027		21,075	79
80	TOTALS			$ 52,413	$	$ 4,027	$ 4,027		$ 41,136	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,612,162	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,690	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 152,736	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,506,782	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehabilitation	$ 62,663	92
93			93
94			94
95		$ 62,663	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 3,218 Description: Postage Meter - $282; Copier - $2,278; Allocated from Management Company - $658
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	17,161	$ 247,493	$	17,161	$ 247,493	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		2,710	39,633		2,710	39,633	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		30,793	332,546		30,793	332,546	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				119,225		119,225	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					28,800			28,800	13
14	TOTAL			$	50,664	$ 648,472	$ 119,225	50,664	$ 767,697	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860
1/1/01 - 12/31/01

Schedule D

Schedule XIV. Special Services
Line 13, Other

Service	Cost	Line Reference
Clinitron Beds	17,269	L 39, C 3
Oxygen	7,917	L 39, C 3
Laboratory	2,605	L 39, C 3
Radiology	1,009	L 39, C 3
Total	28,800	

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 657,974	$ 666,864	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	2,269,415	2,269,415	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,961	56,961	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	61,798	61,798	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,046,148	$ 3,055,038	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		616,761	13
14	Buildings, at Historical Cost		3,661,473	14
15	Leasehold Improvements, at Historical Cost	517,568	794,438	15
16	Equipment, at Historical Cost	475,945	1,539,490	16
17	Accumulated Depreciation (book methods)	(489,044)	(3,506,782)	17
18	Deferred Charges		9,619	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Construction in progr	62,663	62,663	22
23	Other(specify): Unamortized loan costs		17,999	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 567,132	$ 3,195,661	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,613,280	$ 6,250,699	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 286,648	$ 286,648	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,568	123,568	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,454	3,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,000	32
33	Accrued Interest Payable		13,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	164,545	168,389	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 578,215	$ 733,059	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,596,879	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,596,879	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 578,215	$ 3,329,938	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,035,065	$ 2,920,761	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,613,280	$ 6,250,699	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860
1/1/01 - 12/31/01 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	61,156	-
Accrued management fees	28,160	28,160
Accrued wage assignments	(379)	(379)
Accrued 401 (k) contribution	18,293	18,293
401 (k) withholding	8,319	8,319
Other accrued expenses	47,717	47,717
Due to Republic Construction	1,279	1,279
Due to partners		65,000
Total line 36	164,545	168,389

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,159,796	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	(12,958)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,146,838	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,469,227	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,581,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 888,227	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,035,065	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,360,749	1
2	Discounts and Allowances for all Levels	(526,380)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,834,369	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,073,529	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,073,529	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,123	12
13	Barber and Beauty Care	48,316	13
14	Non-Patient Meals	71	14
15	Telephone, Television and Radio	165	15
16	Rental of Facility Space		16
17	Sale of Drugs	157,770	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,699	19
20	Radiology and X-Ray	767	20
21	Other Medical Services	126,170	21
22	Laundry	12,248	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 357,329	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,055	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,055	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bed Hold Revenue	506,641	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 506,641	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,791,923	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,575,414	31
32	Health Care	4,133,892	32
33	General Administration	1,869,758	33
	B. Capital Expense		
34	Ownership	1,387,338	34
	C. Ancillary Expense		
35	Special Cost Centers	233,654	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,322,696	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,469,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,469,227	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,930	2,110	$ 87,578	$ 41.51	1
2	Assistant Director of Nursing	3,638	3,863	100,343	25.98	2
3	Registered Nurses	45,618	48,733	1,156,300	23.73	3
4	Licensed Practical Nurses	16,111	17,383	361,080	20.77	4
5	Nurse Aides & Orderlies	107,210	112,359	1,187,118	10.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,437	9,158	116,539	12.73	8
9	Activity Director	1,419	1,508	21,500	14.26	9
10	Activity Assistants	22,241	23,623	208,556	8.83	10
11	Social Service Workers	1,260	1,335	25,607	19.18	11
12	Dietician	113	121	3,368	27.83	12
13	Food Service Supervisor	3,518	3,680	53,850	14.63	13
14	Head Cook	1,730	1,987	36,452	18.35	14
15	Cook Helpers/Assistants	15,550	16,490	138,985	8.43	15
16	Dishwashers	16,930	17,886	113,203	6.33	16
17	Maintenance Workers	2,381	2,528	73,254	28.98	17
18	Housekeepers	49,638	52,145	342,233	6.56	18
19	Laundry	4,955	5,052	31,056	6.15	19
20	Administrator	2,118	2,118	87,392	41.26	20
21	Assistant Administrator					21
22	Other Administrative	746	751	101,648	135.35	22
23	Office Manager					23
24	Clerical	25,719	27,433	422,244	15.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	331,262	350,263	$ 4,668,306 *	$ 13.33	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,390	L 1, C 3	35
36	Medical Director	Monthly	17,000	L 9, C 3	36
37	Medical Records Consultant	Monthly	600	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	71	3,314	L 11, C 3	44
45	Social Service Consultant	Monthly	2,944	L 12, C 3	45
46	Other(specify)				46
47	Utilization Review	Monthly	150	L 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)	71	$ 37,598		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy McDonald	Administrator	0.00%	$ 87,392
John Samatas	Admin/Plant Ops.	33.33%	17,732
James Samatas	Administrative	33.33%	40,322
Cynthia Thiem	Administrative	33.34%	22,250
George Samatas	Administrative	0.00%	9,084
Jason Samatas	Administrative	0.00%	12,260
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 189,040

B. Administrative - Other

Description	Amount
Management fees (eliminated in Column 7)	$ 397,135
TOTAL (agree to Schedule V, line 17, col. 3)	$ 397,135
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity Co.	401(k) Administration	$ 720
Altschuler, Melvoin & Glasser LLP	Accounting	13,358
American Express Tax & Bus. Svs.	Accounting	5,494
Robert Stachura	Accounting	27
Sachnoff & Weaver	Legal	2,381
James Samatas	Legal	75
Personnel Planners	U/C Consultant	1,310
Royal Management Corp.	Web site development	369
Systematic Management	Billing Consultant	7,012
Freidman, Anselmo & Lindberg	Collections	2,334
AIM	Computer Consultant	2,420
See attached Schedule F		2,166
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,666

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,103
Unemployment Compensation Insurance	37,664
FICA Taxes	354,538
Employee Health Insurance	109,258
Employee Meals	11,628
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	20,853
Employee Transportation	85,374
Other Employee Benefits	11,404
TOTAL (agree to Schedule V, line 22, col.8)	$ 679,822

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	19,472
Health Care Worker Background Check	
(Indicate # of checks performed 79)	954
Miscellaneous Licenses & Permits	960
Miscellaneous Dues & Subscriptions	290
Allocated from Management Company	3,292
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,368

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,808
Allocated from Management Company	1,672
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,480

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860 **Schedule F**
1/1/01 - 12/31/01

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Information Controls, Inc.	Computer Consultant	1,218
Cash Receipts	Collections	330
Environetx	Space Consultant	242
Advanced Answers on Demand, Inc.	Computer Consultant	376
		2,166
Total, Agrees to Schedule V, Line 19, Column 3		37,666
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	1,129
James Samatas	Filing and recording fees	4
Sachnoff & Weaver	Legal	56
BDO Seidman, LLP	Accounting	17
Robert Stachura	Accounting	2
Pension Administrators	401 (k) Administration	239
Various	Consulting	296
Various	Computer Services	5,663
Allocated from building partnership		
James Samatas	Filing and recording fees	50
Nonallowable legal fees		
Freidman, Anselmo, & Lindberg	Legal-collection fees	(2,664)
Sachnoff & Weaver	Out of period legal fees	(497)
Total, Agrees to Schedule V, Line 19, Column 8		41,961

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred Maintenance	1999	$ 2,219	36 mo.	$	$ 370	$ 740	$ 740	$ 369	$	$	$	$
2	Deferred Maintenance	3/1999	1,536	36 mo.		256	512	512	256				
3	Deferred Maintenance	9/1999	3,918	36 mo.		653	1,306	1,306	653				
4	Painting & Decorating	2000	16,681	36 mo.			2,780	5,560	5,560	2,781			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 24,354		$	$ 1,279	$ 5,338	$ 8,118	$ 6,838	$ 2,781	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard **#** 0028860 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **61,316** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,628** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **71**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	345,858	27,393	12,390	385,641	0	385,641	0	385,641
2. Food Pr	0	279,126	0	279,126	0	279,126	-11,699	267,427
3. Housek	342,233	44,309	0	386,542	0	386,542	0	386,542
4. Laundry	31,056	28,541	0	59,597	0	59,597	-12,248	47,349
5. Heat an	0	0	248,347	248,347	0	248,347	3,198	251,545
6. Mainten	73,254	0	142,907	216,161	0	216,161	9,184	225,345
7. Other (s	0	0	0	0	0	0	0	0
8. Total Ge	792,401	379,369	403,644	1,575,414	0	1,575,414	-11,565	1,563,849
9. Medical	0	0	17,000	17,000	0	17,000	0	17,000
10. Nursin	3,008,958	195,825	7,464	3,212,247	0	3,212,247	0	3,212,247
10a. Thera	0	0	619,672	619,672	0	619,672	0	619,672
11. Activiti	230,056	23,052	3,314	256,422	0	256,422	0	256,422
12. Social	25,607	0	2,944	28,551	0	28,551	0	28,551
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	3,264,621	218,877	650,394	4,133,892	0	4,133,892	0	4,133,892
17. Admin	189,040	0	397,135	586,175	0	586,175	-397,135	189,040
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	37,666	37,666	0	37,666	4,295	41,961
20. Fees,	0	0	22,076	22,076	0	22,076	3,292	25,368
21. Clerica	422,244	34,468	22,105	478,817	0	478,817	21,955	500,772
22. Emplo	0	0	621,498	621,498	0	621,498	58,324	679,822
23. Inservi	0	0	320	320	0	320	0	320
24. Travel	0	0	2,808	2,808	0	2,808	1,672	4,480
25. Other	0	0	19	19	0	19	9,672	9,691
26. Insura	0	0	120,379	120,379	0	120,379	2,382	122,761
27. Other	0	0	0	0	0	0	0	0
28. Total G	611,284	34,468	1,224,006	1,869,758	0	1,869,758	-295,543	1,574,215
29. Total G	4,668,306	632,714	2,278,044	7,579,064	0	7,579,064	-307,108	7,271,956
30. Depre	0	0	55,870	55,870	0	55,870	134,820	190,690
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	0	0	0	0	221,369	221,369
33. Real E	0	0	0	0	0	0	130,726	130,726
34. Rent -	0	0	1,328,908	1,328,908	0	1,328,908	########	0
35. Rent -	0	0	2,560	2,560	0	2,560	658	3,218
36. Other	0	0	0	0	0	0	0	0
37. Total G	0	0	1,387,338	1,387,338	0	1,387,338	-841,335	546,003
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	119,225	28,800	148,025	0	148,025	0	148,025
40. Barber	0	0	39,090	39,090	0	39,090	0	39,090
41. Coffee	0	0	685	685	0	685	0	685
42. Provid	0	0	122,640	122,640	0	122,640	0	122,640
43. Other	0	0	45,854	45,854	0	45,854	-45,854	0
44. Total S	0	119,225	237,069	356,294	0	356,294	-45,854	310,440
45. Grand	4,668,306	751,939	3,902,451	9,322,696	0	9,322,696	########	8,128,399

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	657,974	666,864
2. Cash - F	0	0
3. Account	2,269,415	2,269,415
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	56,961	56,961
7. Other Pr	0	0
8. Account	61,798	61,798
9. Other (s	0	0
10. Total cı	3,046,148	3,055,038
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	616,761
14. Buildin	0	3,661,473
15. Leaseh	517,568	794,438
16. Equipm	475,945	1,539,490
17. Accum	-489,044	########
18. Deferre	0	9,619
19. Organi:	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	62,663	62,663
23. other (s	0	17,999
24. Total L	567,132	3,195,661
25. Total A	3,613,280	6,250,699
CURRENT LIABILITIES		
26. Accour	286,648	286,648
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	123,568	123,568
31. Accrue	3,454	3,454
32. Accrue	0	138,000
33. Accrue	0	13,000
34. Deferre	0	0
35. Federa	0	0
36. Other C	164,545	168,389
37. Other C	0	0
38. Total C	578,215	733,059
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	2,596,879
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	2,596,879
46.Total Li	578,215	3,329,938
47.Total Eq	3,035,065	2,920,761
48.Total Li	3,613,280	6,250,699

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,360,749
2. Discounts and Allowances for all Levels	-526,380
Subtotal - Inpatient Care	9,834,369
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,073,529
7. Oxygen	0
Subtotal - Anciliary Revenue	1,073,529
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	1,123
13. Barber and Beauty Care	48,316
14. Non-Patient Meals	71
15. Telephone, Television, and Radio	165
16. Rental of Facility Space	0
17. Sale of Drugs	157,770
18. Sale of Supplies to Non-Patients	0
19. Laboratory	10,699
20. Radiologyand X-Ray	767
21. Other Medical Services	126,170
22. Laundry	12,248
Subtotal - Other Operating Revenue	357,329
24. Contributions	0
25. Interest and Other Investments Income	20,055
Subtotal - Non-Operating Revenue	20,055
27. Other Revenue (specify):	506,641
28. Other Revenue (specify):	0
Subtotal - Other Revenue	506,641
30. Total Revenue	11,791,923
31. General Services	1,575,414
32. Health Care	4,133,892
33. General Administration	1,869,758
34. Ownership	1,387,338
35. Special Cost Centers	233,654
35. Provider Participation Fee	122,640
37. Other	0
40. Total Expenses	9,322,696
41. Income Before Income Taxes	2,469,227
42. Income Taxes	0
43. Net Income or Loss for the Year	2,469,227

Page

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9
10 Attachment of Real Estate Bill and fill out form

11
12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Lexington Health Care C** **03:14 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,194,297	equal to	-1,194,297	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	221,369	equal to	221,369	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	130,726	equal to	130,726	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	190,690	equal to	190,690	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,218	equal to	3,218	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	619,672	equal to	619,672	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	119,225	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,575,414	equal to	1,575,414	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,133,892	equal to	4,133,892	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,869,758	equal to	1,869,758	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,387,338	equal to	1,387,338	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	233,654	equal to	233,654	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,892,419	equal to	3,008,958	-116,539	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	230,056	equal to	230,056	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	25,607	equal to	25,607	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	345,858	equal to	345,858	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	73,254	equal to	73,254	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	342,233	equal to	342,233	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	31,056	equal to	31,056	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	189,040	equal to	189,040	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	422,244	equal to	422,244	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,668,306	equal to	4,668,306	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	12,390	< or = to	12,390	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	17,000	< or = to	17,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,800	< or = to	7,464	-5,664	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,314	< or = to	3,314	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,944	< or = to	2,944	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	189,040	equal to	189,040	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	397,135	equal to	397,135	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	37,666	equal to	37,666	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	679,822	equal to	679,822	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	25,368	equal to	25,368	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,480	equal to	4,480	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,628	< or = to	58,324	-46,696	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,628	equal to	11,628	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,654	equal to	5,926	-272	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-1,109,970	equal to	-1,109,970	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,596,879	equal to	2,596,879	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	138,000	equal to	138,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	616,761	equal to	616,761	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,455,911	equal to	4,455,911	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,539,490	equal to	1,539,490	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,506,782	equal to	3,506,782	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,035,065	equal to	3,035,065	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,469,227	equal to	2,469,227	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	9,619	equal to	9,619	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,613,280	equal to	3,613,280	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1